



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

ALLIED MEDICAL CENTERS
PO BOX 24809
HOUSTON TEXAS 77029

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name

WAL MART ASSOCIATES INC

Carrier's Austin Representative Box

Box Number 53

MFDR Tracking Number

M4-12-0170-01

MFDR Date Received

September 19, 2011

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "According to the AMA/CPT manual, the code 99214 is described as follows: Office or other outpatient visit for the evaluation & management of an established patient, which requires at least two of these three key components: a detailed history; a detailed examination; medical decision making of moderate complexity. Physicians typically spend 25 minutes face to face with the patient and/or family. Our doctors usually spend 25-30 minutes conducting a re-evaluation of established patients. As noted in the typed subsequent report that was submitted with the HCFA billing, you can clearly note that a comprehensive history is documented under Present Medical Condition on our follow-up exam form. A comprehensive examination including nuero & ortho exams were also performed and documented in the exam form. Decision making of moderate complexity was also met and documented in the treatment plan. Plan is noted in the report as well as discussing current medication and referral recommendations."

Amount in Dispute: \$327.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Please note that the office visit notes for procedure 99214 does not support the level of service billed. It requires 2 key components: Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family. The notes do not appear to have 2 components mentioned above and therefore, no additional payment is recommended at this time."

Response Submitted by: Hoffman Kelley

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 5, 2011	99214	\$156.00	\$0.00
April 19, 2011	99214	\$156.00	\$0.00
April 19, 2011	99080	\$15.00	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the fee guideline reimbursement procedure.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits

- 16 – Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks codes whenever appropriate.
- 589 –The documentation received does not support the level of service billed. Please adjust the level of service billed or provide additional documentation to support the service billed.
- 193 – Original payment decision is being maintained. This claim was processed properly the first time.
- 1014 – The attached billing has been re-evaluated at the request of the provider based on this re-evaluation; we find our original review to be correct. Therefore, no additional allowance appears to be warranted.
- 5081 –Reduction or denial of payment resulting after reconsideration was completed.

Issues

1. Did the insurance carrier submit EOBs in support of payment for CPT code 99080-73?
2. Did the requestor document the level of service billed?
3. Is the requestor entitled to reimbursement?

Findings

1. Per 28 Texas Administrative Code §129.5 “(i) Notwithstanding any other provision of this title, a doctor may bill for, and a carrier shall reimburse, filing a complete Work Status Report required under this section or for providing a subsequent copy of a Work Status Report which was previously filed because the carrier, its agent, or the employer through its carrier, asks for an extra copy. The amount of reimbursement shall be \$15. A doctor shall not bill in excess of \$15 and shall not bill or be entitled to reimbursement for a Work Status Report which is not reimbursable under this section. Doctors are not required to submit a copy of the report being billed for with the bill if the report was previously provided. Doctors billing for Work Status Reports as permitted by this section shall do so as follows: (1) CPT code "99080" with modifier "73" shall be used when the doctor is billing for a report required under subsections (d)(1), (d)(2), and (f) of this section.”
 - Review of the documentation in the form of an EOB dated May 18, 2011, supports that the insurance carrier has issued payment in the amount of \$15.00 for CPT code 99080-73. As a result, no further reimbursement is recommended.
2. Per 28 Texas Administrative Code §134.203 “(b) For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules.”
 - CPT code definition for 99214 “Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 25 minutes are spent face-to-face with the patient and/or family.”
 - Review of the submitted documentation for dates of service April 5, 2011 and April 19, 2011 does not meet the minimum documentation requirements for billing CPT code 99214. As a result, reimbursement cannot be recommended.
3. Review of the submitted documentation finds that the requestor is not entitled to reimbursement for CPT code 99214 for dates of service April 5, 2011 and April 19, 2011.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

_____	_____	_____ July 31, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.****

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.